sufficient to enable the State to determine whether the plan complies with the requirements of §§ 417.479(d) through (g) of this chapter. The HMO or HIO must supply this information to the State Medicaid agencies as follows:

(i) Upon application for a contract.

(ii) At least 45 days before implementing any of the following changes in its incentive plan:

(A) A change as to the type of incentive plan.

(B) A change in the amounts of risk or stop-loss protection.

(C) Expansion of the risk formula to cover services not furnished by the physician group that the formula had not included previously.

(iii) Within 30 days of a request by the State or HCFA; and

(4) The HMO or HIO has provided the information on physician incentive plans listed in § 417.479(h)(3) of this chapter to any Medicaid recipient who requests it.

(b) HCFA may withhold FFP for any period during which—

(1) The State fails to meet the State plan requirements of this part;

(2) Either party to a contract substantially fails to carry out the terms of the contract; or

(3) The State fails to obtain from each HMO or HIO contractor proof that it meets the requirements for physician incentive plans specified in §§ 417.479(d) through (g) and (i) of this chapter.

[61 FR 13449, Mar. 27, 1996]

§ 434.71 Condition for FFP: Prior approval.

FFP is not available in expenditures under an HMO contract unless the agency secured prior written notice from the Regional Office, indicating that the contractor meets the definition of an HMO.

§ 434.72 Effect of a final determination that a provisional status HMO is not an HMO.

(a) FFP is available in expenditures for payments to a provisional status HMO until the Public Health Service reaches a final determination that it is not a federally qualified HMO.

(b) The Public Health Service's determination that the entity with provisional status is not an HMO is not considered final until—

(1) All administrative, but not judicial, appeal procedures are exhausted; or

(2) The time for requesting administrative review has lapsed without a request from the HMO.

§ 434.74 Costs under risk-basis contracts.

Under each contract in which the contractor assumes an underwriting risk, the total amount paid by the agency for carrying out the provisions of the contract is a medical assistance cost.

§ 434.75 Costs under no-risk contracts.

Under each contract in which the contractor assumes no underwriting risk—

(a) The amount paid by the agency for furnishing medical services to eligible recipients is a medical assistance cost; and

(b) The amount paid by the agency for the contractor's performance of other functions is an administrative cost.

§ 434.76 Costs under fiscal agent contracts.

Under each contract with a fiscal agent—

(a) The amount paid to the provider of medical services is a medical assistance cost; and

(b) The amount paid to the contractor for performing the agreed-upon functions is an administrative cost.

§ 434.78 Right to reconsideration of disallowance.

A Medicaid agency dissatisfied with a disallowance of FFP under this subpart may request and will be granted reconsideration in accordance with 45 CFR part 16.

§ 434.80 Condition for FFP in contracts with HMOs.

(a) *Basic rule.* FFP in payments to an HMO is available only if the agency excludes from participation as such an entity any entity described in paragraph (b) of this section.

(b) *Entities that must be excluded.* (1) An entity that could be excluded under